Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MARC S BERGER, M.D.
320 N MCCOLL, STE B
MC ALLEN, TX 78501

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-4751-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "we have proof of timely filing"

Amount in Dispute: $1,250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual received the bill 4/26/11…The documents submitted by the requestor clearly do not fall in the category of evidence envisioned by DWC MDR as substantiating timely bill submission. For this reason no payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 7, 2010	72148	$3,000.00	$654.35

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.

5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 25, 2011
   - CAC-29- The time limit for filing has expired.
   - 731- Per 133.20 providers shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/1/05

   Explanation of benefits dated June 27, 2011
   - CAC-193- Original payment decision is being maintained upon review, it was determined that this claim was processed properly.
   - CAC-29- The time limit for filing has expired.
   - 724- No additional payment after a reconsideration of services. For information call 1-800-937-6824
   - 731- Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/1/05.

Issues

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code, Section §408.0272 and 28 Texas Administrative Code §102.4?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."
2. Review of the requestor's submitted documentation finds a bill addressed to the respondent dated 04/26/2010 in box 31, a letter received from Tech Health with a review date of 10/18/2010 stating that the service was unauthorized therefore was denied and requests that the requestor resubmit bill with Tech Health authorization. However, the letter does not inform the requestor of an erroneous submission. Also found is a copy of the patient account notes which show that on 04/21/2011 the requestor was informed of their erroneous submission of the claim to Tech Health. For that reason, the requestor in this dispute was required to submit the medical bill to the correct insurance carrier no later than 95 days after the date they were notified of their erroneous submission of the claim in accordance with Texas Labor Code §408.0272.
3. In accordance with Texas Labor Code §408.0272 and 28 Texas Administrative §102.4(h) the documentation submitted by the requestor sufficiently support that the requestor submitted a bill to the correct insurance carrier within 95 days after the date the provider was notified of their erroneous submission. Therefore, reimbursement is recommended per 28 Texas Administrative Code §134.203 as follows:

   CPT code: 72148: 54.32 WC CF/36.8729 Medicare CF x 444.18 Participating amount = $654.35

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $654.35.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to

the requestor the amount of $654.35 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	02/10/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.